American Arbitration Association
Dispute Resolution Services Worldwide

Demand for Arbitration

NEW JERSEY NO-FAULT AUTOMOBILE ARBITRATION RULES
PERSONAL INJURY PROTECTION (P.I.P.) COVERAGE

Date:

To:
Name of Respondent: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____ Email: _____

Insurance Information Requested:

Name of Policyholder: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Policy Number:_____

Claim File Number of Insurer: _____

Accident Date: _____

Name of Individual with Whom Claim was Last Discussed: _____

Name(s) of Claimant(s):

1. _____ 2. _____

3. _____ 4. _____

Name(s) of Claimant Representative: _____

Name of Firm: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Fax: _____ Email address: _____ Your file #: _____

Items Claimed:

(Please list each Claimant separately.)

Medical Expense Benefits:

Amounts claimed and details thereof including, but not limited to, two copies, by way of attachment, of all invoices in dispute with appropriate transmittal dates attached, and any applicable assignment of rights:

Name of Provider	Date of Treatment	Date Claim Submitted to Insurer	Amount Claimed

Total: ☐

Other:

(Please include date claim submitted to Insurer)

Total: ☐

(Attach additional sheet if necessary)

☐ **Please check if Emergent/Expedited. Enclose additional $100.00 fee.**

Attorney's Fee $_____

Other Costs of the Proceedings $_____

Interest $_____

Other (Please specify.) _____

Accident Location: _____

Hearing Locale Requested: ☐ North ☐ Central ☐ South (Check one)

Medical Review Organization

- Are you requesting a review by the Medical Review Organization?
  (Check one) ☐ yes ☐ no

- If yes, please send four (4) copies of a redacted medical report (one for AAA file, one for the DRP, two for the Medical Review Board) and a check in the appropriate applicable amount, determined by the AAA.

I _____ hereby certify that a copy of this demand, together with all submissions has been served upon the respondent be certified mail return receipt requested. To the best of my knowledge, any and all pending actions in any court or arbitration proceeding which arises out of treatment of the same parties, arises out of the same accident, or which should otherwise be joined in the action being filed is fully set forth below:

_____

_____

_____

Signature: _____ Date: _____

An original and two (2) copies of this Demand, together with two (2) copies of all submissions, are enclosed along with the $285.00 filing fee.

American Arbitration Association
New Jersey Insurance Center
220 Davidson Avenue
Somerset, New Jersey 08873.

Payment Type:

☐ Check (make checks payable to the American Arbitration Association)

☐ VISA ☐ MasterCard Card # _____

Expiration Date: _____ Signature: _____

This new Demand Form is effective May 1, 2003 for all Claims filed on or after May 1, 2003. The new *Rules for the Arbitration of No-Fault Disputes in the State of New Jersey* can be found on the Association's Web site at **www.adr.org**.
